DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 - 0 0 1

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42-CFR 483.1, .10/456,.400, .401

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ No Budget
b. FFY 2005 $ Impact

. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A. p. 7a
Attachment 3.1-A, p. 1f
Attachment 4.14-A, pp 1 & 2.
Attachment 3.1-C, pp 1, 1a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A. p. 7a
Attachment 3.1-A p. 1f
Attachment 4.14-A, pp 1 & 2.
Attachment 3.1-C, p 1

10. SUBJECT OF AMENDMENT:
NEW PROCEDURES -- NURSING FACILITY

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mark Trail

13. TYPED NAME: MARK TRAIL

14. TITLE: CHIEF, MEDICAL ASSISTANCE PLANS

15. DATE SUBMITTED:
March 24, 2004

16. RETURN TO:
Department of Community Health
Medical Assistance Plans
2 Peachtree Street
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 25,2004

18. DATE APPROVED:
May 27, 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Renard L. Murray

21. TYPED NAME:
Renard L. Murray, D.M.

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

METHODS AND STANDARDS TO ENSURE QUALITY OF SERVICES

Provider Standards

Prior to enrollment, providers must satisfy licensing and certification requirements established by local and Federal laws, regulations, and State agency policies.

Assessment of Long-Term Care Services

Pre-admission reviews are done to determine the appropriate level of care needed by applicants for long-term care. The physician certifies that alternatives to nursing home care have been considered but are not appropriate. Periodic evaluations are made of the adequacy and appropriateness of services rendered and the patient's need for continued placement in the present facility.

Peer review evaluation are provided under contract per Georgia Health Partnership (GHP) by Registered Nurses and consulting Physicians to ensure that the State's responsibility for pre-admission screening and review of Mentally Ill and Mentally Retarded (PASRR) services as governed by 42CFR483.100 through 483.138, based on section 1919(e)(7) of the Social Security Act is completed. The contractor utilizes the DMA-613 Level 1 instrument to assess each applicant who seeks admission, into a NF and/or each NF resident who has MI or MR, is medically necessary and appropriate.

The GHP evaluator must assess whether the individual's total needs are such that his or her needs can be met in the NF by prioritizing the physical and mental needs of the individual being evaluated, taking into account the severity of each condition. If the peer review decides that further assessment is necessary, they will notify other State contracted mental health or mental retardation authorities (PASRR Contractor, Level 2) who determine whether an NF level of service is feasible and is the appropriate facility for placement.

Surveillance and Utilization Review (SUR)
SUR reviews are done in all Medicaid services and are primarily concerned with medical necessity; quality, appropriateness and frequency of services; adequate documentation to support services billed; policy violations and incorrect payments. In-house reviews are made from SUR system reports including profiles, weighted and ranked, and submitted claims' detail. Provider medical records are reviewed on-site. Questionable practices involving medical necessity and quality are referred to the peer review agency for review and recommendation.
Home Health Agency Reviews
Authorized representatives of the Department review home health agencies as directed by the Department. Functions included in these utilization reviews are assessments of quality of care and need for services rendered. Records are reviewed in the agencies and patients are assessed in their homes. Visits may be announced or unannounced.

Certification of Need for Care

Prior to a patient being admitted to a facility or transferred between facilities, the patient' s attending physician will evaluate the need for Nursing Facility placement by assessing social and medical information. This also includes the physician completing and signing the DMA-6. The DMA-6 verifies certification by the physician that the applicant is determined eligible for Nursing Facility Level of Care. When certification of Level of Care is assigned it is valid for sixty (60) days. Certifications and attestations for the Level of Care are performed according to Federal timeliness requirements.

Review Medical Evaluation and Admission

Before admission to an institution for the mentally retarded or related conditions, Intermediate Care Facility for the Mentally Retarded (ICFMR), an interdisciplinary team of health professionals makes a comprehensive medical and social evaluation and a psychological evaluation of each applicant's/ recipient's need for care in the ICFMR.

Evaluations made before admission include:

- Diagnoses.
- Current medical, social and developmental findings.
- Mental/ physical functional capacity.
- Prognoses.
- Services needed.
- Recommendation of admission to or continued ICFMR care.

Plan of Care

A physician must legalize a written plan of care, the active treatment services, by personally signing the plan for each applicant or recipient before admission to an ICFMR. Medical and social information is required to be submitted on the Plan of Care which contains the following elements:

- Identification of the recipient.
- Name of the recipient' s physician.
- Date of admission.
- Dates of application for and authorization of Medicaid benefits if application is made after admission.
- Diagnoses, symptoms, complaints, and complications indicating the need for admission.
- Description of the functional level of the individual.

Plan of Care: Nursing Facilities (Continued)

- Objectives.
- Orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures designed to meet the objectives of the plan of care.
- Plans for continuing care, including review and modification of the plan of care.
- Plans for discharge.

The team must review and follow through each plan as required by 42CFR483.440.

Explanation of Alternative Services

Before admission to a ICFMR, if the physician recommends services for an applicant or recipient whose needs could be met by alternative services that are currently unavailable, the facility must enter this fact in the recipient's record and begin to look for alternative services.

15. a. NURSING FACILITY SERVICES

Prior to admission to a Nursing Facility, evaluation is provided for each patient. A physician's review is performed periodically to determine:

- the need for continued placement at this level of care.
- the adequacy, appropriateness and quality of services received.
- the feasibility of meeting the recipient' s health and rehabilitative needs through alternative arrangements.

15. b. INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED (ICFMR)

Prior to admission to an ICFMR, evaluation is provided for each patient. Independent professional review is performed periodically to determine:

- the need for continued placement at this level of care.
- the adequacy, appropriateness and quality of services received.
- the feasibility of meeting the recipient' s health and rehabilitative needs through alternative arrangements.
- whether the recipient is receiving active treatment for mental retardation or related mental conditions.

4.a. Nursing facilities provide nursing or rehabilitative care on a daily basis. Covered services include room and board (including special diets and special dietary supplements used for tube or oral feedings, when specifically prescribed by a physician), laundry (including personal laundry), nursing services (except private duty nurses), medical social services, physical therapy, speech therapy, restorative nursing care, tray services, durable medical equipment, incontinency care and incontinency pads, hand feedings, special mattresses and pads, massages, syringes, enemas, dressings, laboratory procedures not requiring laboratory personnel, non-prescription drugs such as, antacids, aspirin, suppositories, magnesium hydroxide liquid, mineral oil, rubbing alcohol, prophylactic medications, oxygen, catheters, catheter sets, drainage apparatus, intravenous solutions, administration sets and water for injections. Personal comfort or cosmetic items not covered.

Adjunctive services (those not included in the established reimbursement rate) are covered only on written authorization in the plan of care by the attending physician. Drugs included on the Medical Assistance Drug List or those specially approved by the Department are available through the Pharmacy Services Program.

Pre-admission approval of a nursing facility level of care must be obtained from a physician authorizing nursing facility placement by completing and signing a DMA-6 form for those applying to Medicaid for payment of facility services.

Voluntary supplementation may be paid directly to providers by relatives or other persons for the additional cost of a private room and/or sitter for Title XIX recipients in nursing homes (Ga. Act. 1323). These supplemental payments are not considered as income when determining the amount of patient liability toward vendor payments. Provision of a private room and/or sitter through supplemental payment will not constitute discrimination against other recipients. No recipient who is admitted/transferred to a private room due to a shortage of beds in semi-private rooms may be discharged due to lack of voluntary supplementation. Charges for private rooms may not exceed rates charged to private patients.